SD EForm - 1077 V1

HELP

Complete and use the buttons at the end to send electronically or to print for mailing.

DSS-MS-103O-01/03

MEDICAL ASSISTANCE MANAGED CARE PROVIDER CHANGE FORM

SECTION 1 – REASON FOR CHANGING YOUR PCP

When requesting a change in your Primary Care Provider selection **please state your main reason for requesting a change.**

- ○ Long waiting periods to see the Doctor
- ○ Not being referred (authorized) to specialists when medically necessary
- ○ Doctor (or on-call staff) not available 24 hours a day, 7 days a week
- ○ Dissatisfaction with PCP
- ○ PCP not accepting new patients
- ○ Moved to new area
- ○ Other

NOTE: IF YOUR CHANGE REQUEST IS APPROVED, YOUR NEW PCP DOES NOT TAKE EFFECT IMMEDIATELY. CHANGE APPROVALS ARE EFFECTIVE ON THE FIRST DAY OF THE MONTH AFTER APPROVAL.

SECTION 2 – NEW PRIMARY CARE PROVIDER(S)

	MANAGED CARE RECIPIENT'S NAME (Family members eligible for Medical Assistance)	RECIPIENT ID NUMBER (from notice or ID card)	PRIMARY CARE PROVIDER NAME (from Provider list)	PCP CODE (from Provider list)
0				
1				
2				
3				
4				
5				
6				
7				
8				
9				

I understand the Medical Assistance Managed Care Program rules and requirements and also understand that by not following those rules and requirements I may be responsible for payment of medical bills. Refer to the *Medical Assistance Program Recipient Handbook* for more information.

Your Name_____

Telephone Number_____

By typing your name above, you are declaring and affirming under the penalties of perjury that the information you are submitting has been examined by yourself, and to the best of your knowledge and belief, is in all things true and correct

Date_____

1. SEND ELECTRONICALLY or PRINT FOR MAILING

CLEAR FORM